Healthy Connections

South Carolina Department of Health and Human Services

Additional Information for Institutional and In-Home Care

☐ **Nursing Home** ☐ **In-Home Care**

This form is used to gather other information needed to make a decision about eligibility for Nursing Home, Institutional or In-Home care. All of the rights and responsibilities agreed to when the original application was signed are still in effect. If there are any questions about those rights and responsibilities or questions about this form, please contact Healthy Connections at 1-888-549-0820.

1. Who is the person needing assistance?

a. Name (First, Middle, Last) _____

b. Social Security Number _____

c. Date of birth (mm/dd/yyyy) _____

2. Where is the person right now? ☐ Home ☐ Hospital ☐ Nursing Home ☐ Other

If not at home, tell us where the person is.

Name of facillity: _____

Date entered facility: _____

3. Please check if anyone has Conservatorship, Guardianship, or Power of Attorney for the applicant.

If yes, please give us a copy of the legal papers and the name and phone number of the person.

☐ Conservatorship Name: _____

☐ Guardianship Name: _____

☐ Power of Attorney Name: _____

4. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to spouse remaining at home? ☐ Yes ☐ No

5. If there are dependent children or dependent adults, does the applicant want to give (allocate) income to the dependent children or dependent adults? ☐ Yes ☐ No

6. Has the applicant or spouse ever worked somewhere that has a retirement benefit for which he or she may be eligible to receive money? ☐ Yes ☐ No

If YES, who was working, where and for how long? _____

7. Do you or anyone in your home receive, or have applied for, any other income? ☐ Yes ☐ No

Before we can make a decision on your application, you may have to give us proof of income for the past 4 weeks.

If **YES**, check all boxes that apply and complete the table below. If you have already told us about a type of income on your application, you do not have to tell us about it again.

☐ Supplemental Security Income (SSI) ☐ Child support ☐ Disability benefits

☐ Veterans Administration (VA) benefits ☐ Military allotments ☐ Money from friends or relatives

☐ Federal retirement (Civil Service, FERS) ☐ Land contract, mortgage or other notes payable to a household member (Please provide a copy of the contract, mortgage, note or other agreement)

Person receiving/expecting money	Income source/type	How often received	Amount received	Comments

8. Please check the box beside any of the things shown that you or someone in your home owns or are buying. Tell us about it in the table. When you return this form, you must send proof of these assets or resources.

- ☐ Bank Checking Account
- ☐ Bank Savings Account
- ☐ Certificate of Deposit
- ☐ Trust Fund or Trust Account
- ☐ Safe Deposit Box (include contents)
- ☐ Car, Truck, Van
- ☐ Annuity (provide a copy)
- ☐ Cash on Hand
- ☐ Stocks, Bonds, Mutual Funds
- ☐ Motorcycle, Boat, Camper
- ☐ Farm Machinery or Business Equipment
- ☐ Pre-Need Burial Contract
- ☐ Cemetery Burial Space
- ☐ Money Set Aside for Burial
- ☐ DirectExpress Debit Card for SSA, SSI or other benefits
- ☐ 401k, IRA, or Retirement Account
- ☐ Life Insurance
- ☐ Other: _____
  please be specific

Owned by	Tell Us About The Asset Include the name of bank or funeral home, and any account numbers or other information used to identify the asset.	Current Value or Balance
a.		
b.		
c.		
d.		
e.		
f.		

9. Do you or your spouse own any property?

If you answer YES to any of the following questions, please tell us about the property.

Home (house, buildings and land where you live)	☐ Yes	☐ No
Other House or Building (not your home)	☐ Yes	☐ No
Land (not connected to the home)	☐ Yes	☐ No
Vacation Home or Time Share Property	☐ Yes	☐ No

What is the address/location of the property?
List Home Property First

_____

_____

_____

Owner's Name: _____

Is this your Home Property or Primary Residence where you currently live or where you want to return to live if you are living somewhere else?

☐ Yes ☐ No

What is the address/location of the property?

_____

_____

_____

Owner's Name: _____

10. Does anyone else have a bank account or any other asset for the applicant or spouse?

☐ **Yes** ☐ **No**

If YES, at what bank or location, and in whose names? _____

11. Has the applicant or spouse closed any bank accounts in the past five (5) years? ☐ Yes ☐ No

If YES, at what bank, and in whose names?

A. _____ B. _____

Date Closed: _____ Date Closed: _____

Closing Balance: _____ Closing Balance: _____

12. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person any time in the past five (5) years? ☐ Yes ☐ No

Item Sold or Given Away	Person to whom it was Sold or Given	Date Given or Sold	Amt. Received

13. Where has the applicant lived in the past five (5) years?

City	County	State Use 2-letter abbreviation	From	To

14. If ever married, give the following information about the applicant's spouse(s). (List the most recent first.)

Name of most recent spouse: _____

☐ Living

☐ In a medical facility ☐ Separated: when or how long? _____

☐ Married, living together ☐ Divorced (list Date, State and County where divorce was filed):

☐ Married, living apart (not separated) _____

Current Address: _____ Phone number: _____

☐ Deceased

Date of death: _____ State and County where estate was probated: _____

Name of next most recent spouse: _____

☐ Divorced Date and place divorce was filed: _____

☐ Deceased Date of death: _____

State and County where estate was probated: _____

Name of next most recent spouse: _____

☐ Divorced Date and place divorce was filed: _____

☐ Deceased Date of death: _____

State and County where estate was probated: _____

15. Give the following information about the applicant's mother and father, if known.

Mother: _____

☐ **Living** Address: _____ Phone number: _____

☐ **Deceased** Date of Death: _____ County & State where estate was probated: _____

Father: _____

☐ **Living** Address: _____ Phone number: _____

☐ **Deceased** Date of Death: _____ County & State where estate was probated: _____

Signature of person completing this form:	**Relationship**

Please print this form, then sign it on the line above before submitting.

ESTATE RECOVERY

(BE SURE TO GET A COPY OF THE ESTATE RECOVERY BROCHURE)

As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:

- A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
- A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

FOR SCDHHS USE ONLY	
Verifications in File: ☐ DHHS 1255 ME ☐ DHHS 1253 ME	**Level of Care Verified:** ☐ Intermediate ☐ Skilled ☐ SNF (Medicare)
Checked for Transfers: ☐ Yes ☐ No	**Were any Transfers Discovered:** ☐ Yes ☐ No
Calculated Sanction Period: _____	